

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/15/2015
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF SOUTH BEND		STREET ADDRESS, CITY, STATE, ZIP CODE 52565 STATE ROAD 933 SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This survey was for the Investigation of Complaint IN00176208.</p> <p>Complaint IN00176208 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: July 15, 2015</p> <p>Facility number: 013302 Provider number: 155824 AIM number: 201281730</p> <p>Census bed type: Residential: 24 Total: 24</p> <p>Sample: 3</p> <p>Wellbrooke of South Bend was found to be in compliance in with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00176208.</p>	R 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE